Anthem Preferred DirectAccess ccax

Summary of Benefits

This summary identifies Deductible, Copayment and Co-insurance options that the Member will pay, and a brief description of Covered Services. This Summary of Benefits does not explain in detail the benefits, exclusions, limitations, Deductibles or Out-of-Pocket Maximums. For a complete explanation, You should read Your whole Certificate to know the terms of Your coverage because many parts are related. Therefore, reading just one or two sections may not give You a full understanding of Your coverage.

Reimbursement for Covered Services is based on the Maximum Allowed Amount, which is the most Your Certificate will allow for a Covered Service. For more complete information, see Your Certificate or call the HMO Nevada Customer Service Department toll free at (855) 330-1217.

Service Area	
Areas of Nevada where the plan is available	The plan is available throughout Nevada. Covered providers are available through the Pathway Enhanced managed care network. Go to the directory of In-Network Providers at www.anthem.com for list of Providers that participate in the network.

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

	In-Network (HMO Providers)
Annual Deductible	Individual Deductible $750 per Benefit Period Family Deductible $1,500 per Benefit Period Once the total of charges for Covered Services for two or more Members equals the family Deductible, no additional Deductible is required for all Members for the rest of that Benefit Period. • An individual family Member cannot contribute more than half of the family Deductible amount towards satisfying the family Deductible amount. If an individual family Member has satisfied one half of the family Deductible, this individual Member has satisfied their individual Deductible for the current Benefit Period. • The family Deductible continues to apply to all other family Members until all of the family Deductible amount has been satisfied. The Deductible applies to all Covered Services with a Co-insurance, including 0% Co-insurance, except for In-Network Preventive Care Services required by law.

	In-Network (HMO Providers)
Out-of-Pocket Annual Maximum	Individual: $6,000 per Benefit Period. Includes Copayments, Co-insurance, and Deductible. Family: $12,000 per Benefit Period. Includes Copayments, Co-insurance, and Deductible. Once the total of charges for Covered Services for two or more Members equals the family Out-of-Pocket Annual Maximum, no additional Deductible, Copayments, and/or Co-insurance are required for the rest of that Benefit Period. • An individual family Member cannot contribute to more than half of the family's Out-of-Pocket Annual Maximum amount. If an individual family Member has satisfied one half of the family Out-of-Pocket Annual Maximum, this individual Member has satisfied their individual Out-of-Pocket Annual Maximum for the current Benefit Period. • The family Out-of-Pocket Annual Maximum continues to apply to all other family Members until all of the family Out-of-Pocket Annual Maximum amount has been satisfied.

Services	In-Network (Out-of-Network care is not covered except as noted)	Additional Information
1) Physician Visits		For laboratory, pathology and x-ray services, (performed in conjunction with a Physician's office visit,) see Section 3 for payment information.
a) Physician office visits, Physician consultations, and Retail Health Clinic	$30 Copayment per office visit	
b) Specialists, Online Visits, and Inpatient/Outpatient	0% Co-insurance after Deductible	
c) Telemedicine	Benefits are based on the setting in which Covered Services are received.	
2) Preventive Care	No Deductible or Co-insurance (100% covered)	Services include those that meet the requirements of federal and state law including certain screenings, immunizations contraceptives and office visits. For additional information about these services, view the following federal government website: https://www.healthcare.gov/what-are-my-preventive-care-benefits
3) Diagnostic Services, Laboratory, Pathology, and X-ray	You pay 0% Co-insurance after Deductible	Benefits are based on the setting in which Covered Services are received.
4) Maternity Care		
a) Office Visits Services	Covered under Physician Visits. See Section 1 for payment information	
b) Delivery and inpatient baby care	Covered under Inpatient Hospital Care. See Section 7 for payment information	

Services	In-Network **(Out-of-Network care is not covered except as noted)**	Additional Information
5) Therapy Services a) Physical, Speech and Occupational Therapy b) Chiropractic Care and Spinal Manipulation c) Cardiac Rehabilitation	You pay 0% Co-insurance after Deductible	Limited to an aggregate of 60 visits total for Physical, Occupational and Speech Therapy per Member per Benefit Period. Chiropractic Care and Spinal Manipulation is limited to a combined maximum of 50 visits per Benefit Period. Rehabilitation and habilitation therapy services are subject to a maximum of 60 visits each per Benefit Period. Benefits are paid up to 36 visits for cardiac rehabilitation. The program must start within 3 months of the major cardiac event and be completed within 6 months of the major cardiac event.
6) Autism Services	Benefits are based on the setting in which Covered Services are received.	Applied Behavior Analysis benefit maximum per Benefit Period: 500 hourly sessions. Benefits are provided to covered Members under 18 years of age or, if enrolled in high school, until the Member reaches 22 years of age. See Section 5 for additional therapy services.
7) Inpatient Hospital Care	You pay $500 Copayment per admission, then 0% Co-insurance after Deductible.	Bariatric Surgery/Gastric Bypass is limited to one surgery every five years.
8) Outpatient/Ambulatory Surgery	You pay 0% Co-insurance after Deductible	
9) Emergency Care	After a $200 Copayment per emergency room visit, You pay 0% Co-insurance after Deductible	Care is covered In-Network and Out-of-Network. Copayment is waived if admitted.
10) Urgent Care	After a $50 Copayment per urgent care visit, You pay 0% Co-insurance after Deductible	For laboratory, (pathology and x-ray services) see Section 4 for payment information.

Services	In-Network **(Out-of-Network care is not covered except as noted)**	Additional Information
11) Ambulance Services (Ground, air and water services)	You pay 0% Co-insurance after Deductible	Care is covered In-Network and Out-of-Network. Benefits are paid for Medically Necessary ground, air or water ambulance transportation. Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute facility to another, must be approved through precertification.
12) Mental Health and Substance Abuse Care		
a) Inpatient	You pay 0% Co-insurance after Deductible	
b) Outpatient	You pay 0% Co-insurance after Deductible	
c) Professional	Covered under Physician Visits. See Section 1 for payment information	
13) Medical Supplies and Equipment	You pay 0% Co-insurance after Deductible	Includes diabetic supplies and equipment, medical supplies, Durable Medical Equipment, oxygen and equipment, Orthopedic Appliances, prosthetic devices and other appliances. Hearing aids: Limited to a single purchase. Repairs and replacement limited to once every 3 years.
14) Home Health Care	You pay 0% Co-insurance after Deductible	Limited to 30 visits per Member per Benefit Period.
15) Chemotherapy, Hemodialysis, and Radiation Therapy		
a) Inpatient	Covered under Inpatient Hospital Care. See Section 7 for payment information.	

Services	In-Network **(Out-of-Network care is not covered except as noted)**	Additional Information
b) Outpatient	You pay 0% Co-insurance after Deductible	
c) Professional	Covered under Physician Visits. See Section 1 for payment information.	
16) Skilled Nursing Facility	You pay 0% Co-insurance after Deductible	Copayment is waived if admitted directly to a skilled nursing facility from an inpatient acute facility. Limited to 100 days per Member per year.
17) Hospice Care	You pay 0% Co-insurance after Deductible	
18) Human Organ and Tissue Transplants		The following services are covered, subject to approval by Anthem:
a) Inpatient	Covered under Inpatient Hospital Care. See Section 7 for payment information.	Procurement up to a maximum Anthem payment of $15,000 per transplant.
b) Outpatient	You pay 0% Co-insurance after Deductible	Travel expense up to a maximum Anthem payment of $10,000 per transplant. Daily lodging and meals up to a maximum Anthem payment of $200 per day.
c) Professional	Covered under Physician Visits. See Section 1 for payment information.	See the Certificate for details on covered transplants
19) Temporomandibular Joint Syndrome	You pay 0% Co-insurance after Deductible	
20) Enteral Formula and Special Foods	You pay 0% Co-insurance after Deductible	Special food products that are prescribed or ordered by a Physician as Medically Necessary for certain inherited metabolic disorders are allowed.
21) Prescription Drugs		

Services	In-Network (Out-of-Network care is not covered except as noted)	Additional Information
	Retail Pharmacy: • Tier 1: $15 Copayment for each prescription and/or refill for a maximum 30 day supply. • Tier 2: $40 Copayment for each prescription and/or refill for a maximum 30 day supply. • Tier 3: After the calendar year Deductible has been satisfied, 0% Co-insurance for each prescription and/or refill for a maximum 30 day supply. • Tier 4: After the calendar year Deductible has been satisfied, 0% Co-insurance for each prescription and/or refill for a maximum 30 day supply. Specialty Prescription Drugs: After the calendar year Deductible has been satisfied, 0% Co-insurance for each prescription and/or refill for a maximum 30 day supply. Please see Your Certificate for details on covered Specialty Prescription Drugs Home Delivery: • Tier 1: $30 Copayment for each prescription and/or refill for a maximum 90 day supply (mail order). • Tier 2: $100 Copayment for each prescription and/or refill for a maximum 90 day supply (mail order). • Tier 3: After the calendar year Deductible has been satisfied, 0% Co-insurance for each prescription and/or refill for a maximum 90 day supply (mail order)/30 day supply (Specialty Prescription Drugs).	

Pediatric Vision Services

The following benefits are available to Members through age 18. Coverage is only provided when services are received from an In-Network Provider.

	Copayment/Allowance
Routine Eye Exam	$0 Copay
Once every Benefit Period	

	Co-insurance
Standard Plastic Lenses*	
Once every Benefit Period	
Single Vision	$0 Copay
Bifocal	$0 Copay
Trifocal	$0 Copay
Progressive	$0 Copay
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available for services received from In-Network Providers.	
Frames* (formulary) This plan offers a selection of covered frames.	$0 Copay
Once every Benefit Period	
Contact Lenses* (formulary) This plan offers a selection of covered contact lenses.	
Once every Benefit Period	
Elective (conventional and disposable)	$0 Copay
Non-Elective	Covered in full
Low Vision	
Comprehensive Low Vision Exam	$0 Copayment
Once per calendar year.	

Optical/Non-optical aids/Supplemental Testing	$0 Copayment
Limited to one occurrence of either optical/non-optical aids or supplemental testing per calendar year.	

*If You receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until You satisfy the benefit frequency listed.